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No. 01-248

IN THE

Supreme Court of the United States

ULSTER HOME CARE INC., *et al.*,

Petitioners,

-and-

DANIEL RUBIN,

Petitioner,

v.

ELIOT SPITZER,
as Attorney General of the State of New York,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE NEW YORK COURT OF APPEALS

BRIEF OF THE NEW YORK STATE ASSOCIATION OF HEALTH CARE PROVIDERS, INC. AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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PRELIMINARY STATEMENT AND INTEREST OF *AMICUS CURIAE*

The New York State Association of Health Care Providers, Inc. ("HCP") submits this *amicus curiae* brief in support of Ulster Home Care, Inc. ("Ulster Home Care" or "UHC"), petitioner in this application for a Writ of Certiorari to the New York Court of Appeals. HCP is a not-for-profit industry association representing the interests of over 600 licensed home care services agencies, certified home health agencies, long-term home health care programs, and hospice service providers throughout New York State.[1] As set forth below, the New York State Attorney General's numerous attempts, since 1998, to prosecute UHC based solely on his interpretation of an administrative regulation promulgated by the Department of Social Services ("DSS"), 18 N.Y.C.R.R. § 505.14(h)(7)(ii) ("Regulation"), violates public policy, legislative intent, and the express regulatory purpose underlying the Regulation. HCP respectfully submits that this Court should grant certiorari to review the New York State Court of Appeals Opinion reversing the Supreme Court Appellate Division, Third Department's Order reversing the lower Court's denial of UHC's motion for summary judgment.

STATEMENT OF FACTS

A. This Litigation

HCP incorporates herein by reference the Statement of the Case set forth in Petitioner UHC's brief on pages 2-9.

B. Personal Care Program

Under the Medicaid personal care program, the federal government, State and counties share the costs involved in providing personal care to Medicaid-eligible needy citizens. Personal care services are generally provided by certain home

1. The parties have consented to the filing of this brief. Their letters of consent are being lodged herewith. This brief has been authored in its entirety by undersigned counsel for the *amicus curiae*. No person or entity, other than the named *amicus curiae* and its counsel, made any monetary contribution to the preparation and submission of this brief.

care agencies ("providers") which contract with local governments to provide services to Medicaid beneficiaries.[2]

(a) 1990 Legislation

Prior to the 1990 legislation, each of the State's counties negotiated all personal care contracts with providers serving its Medicaid populations. While the State had the authority to disapprove, and thereby undo, the contracts entered into by the counties and the providers, the State routinely: (1) failed even to indicate its approval or disapproval of the contract until one to two years after submission; and (2) failed to make timely reimbursements — sometimes for as long as two years after services were rendered.

To remedy these problems, in 1990, the Legislature mandated a more equitable and consistent reimbursement scheme by enacting Chapter 53 of the Laws of 1990. The Legislature mandated, *inter alia*, that DSS (in consultation with personal care providers, local departments of social services and a panel of independent economists) prepare and submit a plan containing criteria for implementation of a rate setting methodology for personal care services. This rate setting methodology was required to consider, at minimum: (1) changes in the cost of living; (2) applicable minimum wage laws; (3) changes in pertinent economic indicators published by the federal government; (4) administration, operation and clinical factors; (5) the cost of training personal care workers; and (6) the development of a rate year that coincided with the calendar year.

(b) 1994 Regulations

In accordance with the legislative mandate set forth in the new statute, DSS promulgated a comprehensive set

2. Approximately 90% of the recipients of personal care services in New York State are elderly, disabled and/or ill, and 10% are children with disabilities, congenital problems, and chronic illnesses. The personal care client population has grown in size as well as in need. This change has been triggered, in part, by the changes in hospital reimbursement in the 1980s and 1990s that resulted in hospitals discharging patients earlier than before.

of regulations which became effective on January 1, 1994. In essence, DSS decided to replace negotiated rates with rates which would reflect providers' *actual costs* for personal care services. As compared to the prior, negotiated rates, these rates were intended to be more uniform and consistent throughout the State.

The regulations promulgated by DSS specified that personal care providers be reimbursed at the lower of: (1) their charge to the general public for personal care services; or (2) the rate for such services determined by DSS using the cost-based methodology set forth in the regulations. While the phrase "charge to the general public" is referenced in one place in the regulations, there is no definition of the phrase. Moreover, during the three year period when various methodologies were considered, the "general public" charge was given no focus. In sharp contrast, the second prong, pertaining to the rate determined by DSS, was discussed in minute detail and is the subject of a comprehensive methodology set forth at length in 18 N.Y.C.R.R. § 505.14(h)(7). Indeed, prior to the Attorney General's application of the "general public" charge, that standard had never been defined. Since the regulations went into effect on January 1, 1994, DSS has uniformly applied the rate reimbursement methodology to assess providers' actual costs and to determine the appropriate Medicaid reimbursement rate.

(c) HCP's Members and Clients

Approximately 70% of HCP's members provide personal care services to Medicaid recipients. In addition, these agencies typically provide personal care services to two other groups: (1) other public and private agencies under subcontract;[3] and (2) private pay clients.

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3. Personal care providers subcontract with state agencies, adult homes, assisted living facilities, long-term home health care programs and the statutory Expanded In-Home Services for the Elderly Program. Notably, DOH has determined that these subcontracts may be negotiated by providers at rates *lower* than their Medicaid rates.

The private pay clients served by HCP's members generally consist of uninsured individuals. Although some private pay clients have the financial resources necessary to pay the full published rates, the majority of private pay clients, however, are simply unable to do so. This group of clients consists primarily of individuals who do not qualify for Medicaid, but nevertheless, lack adequate financial resources. In the parlance of public assistance, these individuals are known as the "working poor."[4]

The services provided to Medicaid and self-pay clients and, thus, the reimbursement rate, are distinctly different, in the following ways: (1) self-pay clients receive services that are different in kind and quantity from those provided to Medicaid clients; (2) some self-pay clients actually pay *more* for services received than Medicaid does; (3) Medicaid requires a unique administrative overlay that raises the cost of services provided to Medicaid beneficiaries[5]; and (4) self-pay individuals are able to select the services they need, without regard to Medicaid requirements.[6]

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4. Across the State of New York, the personal care services provided to these groups tend to fall into the following percentage ranges: 65% - Medicaid personal care recipients, 30% - subcontracts for personal care, and 5% - private pay/self pay. It is not uncommon, however, for providers in New York State to provide 95% of their personal care services to Medicaid recipients, with only 5% going to self-pay clients.

5. Under the 1994 regulations, Medicaid personal care providers are required, by definition, to undertake considerable additional administrative and management obligations.

6. It impossible to fairly compare Medicaid charges to the charges paid by self-pay clients. There are many items of cost associated with participation in the Medicaid personal care program that simply do not exist with self-pay clients (i.e., certain levels of case coordination and nursing supervision, additional staff to coordinate case management with the counties, preparation of annual cost reports and other regulatory compliance documentation, employee training, and compliance with health and safety standards — none of which are required for self-pay clients). In addition, Medicaid bundles all costs into one all-inclusive

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Private pay rates cover a variable spectrum ranging from the rates paid by individuals who are capable of paying the full published rates, to individuals who have a compelling need for personal care but no means to pay. Some clients pay for services on a "sliding scale" basis, paying as much as they can afford for the services they need. In addition, providers often have a charitable mission or purpose that mandates that they provide services to persons in need below the cost of providing them. The limited number of self-pay clients, as well as the often limited nature of the services provided, allow providers to extend personal care services to those in need without suffering significant financial detriment.

ARGUMENT

I.

THE ATTORNEY GENERAL'S UNPRECEDENTED APPLICATION OF A "PUBLIC CHARGE" REIMBURSEMENT RATE IS IMPERMISSIBLE AND UNDERMINES THE PURPOSE AND INTENT OF THE STATUTE, REGULATIONS AND NEW YORK STATE PUBLIC POLICY

Throughout the last 30 years, the New York State Legislature has repeatedly and consistently pronounced its commitment to provide essential health services for those in need:

> Medical assistance for needy persons is hereby declared to be a matter of public concern and a necessity in promoting the public health and welfare and for promoting the state's goal of making available to everyone, regardless of race, age, national origin or economic standing, uniform, high-quality medical care.

(Cont'd)
rate. Self-payers are able to select specific, limited services, and will typically select only the services that are essential to them. Medicaid clients typically use more services because, among other things, there is no cost to do so.

See Social Services Law § 363 (as enacted in 1966); *see also* Social Services Law §§ 363-a, 365-a.

In 1977, the Legislature explicitly recognized the vital role that home health care services play in the health care delivery system when it passed legislation creating certified home health agencies. At that time, the Legislature declared that provision of "high-quality home care services to residents of New York is a priority concern" and unequivocally articulated a commitment to home care services provision and expansion. *See* Public Health Law § 3600 (reproduced at Appendix A).

As discussed below, both the Legislature and DSS (now DOH), the administrative agency to which the State specifically delegated policymaking authority and directives, made clear their intention to establish an equitable cost-based reimbursement methodology for personal care reimbursement rates. By his criminal prosecution of UHC, the Attorney General has sought to apply a contrary, unprecedented, and legally unfounded, interpretation of the appropriate standard for Medicaid reimbursement to UHC. The Attorney General's unilateral interpretation of a regulation not of his making, contravenes the clear intent of both the Legislature and DSS, as well as New York State's public policy supporting development and expansion of personal care services and will have a devastating impact on personal care providers and the individuals to whom personal care services are provided.

A. The Attorney General's Interpretation Violates The Legislature's Intent.

In 1990, the New York State Legislature mandated DSS to develop and establish a rate reimbursement methodology for personal care services. The Legislature expressly instructed DSS to work in consultation with personal care providers, local departments of Social Services and a panel of independent economists to submit "a plan containing the criteria for the establishment of a rate setting methodology for personal care services. . . ." L. 1990, ch. 53.

The five factors stated by the Legislature, *see* Statement of Facts (B)(a), *supra*, at 2, gave DSS a directive on which to develop the personal care rate reimbursement methodology — a methodology that is based on providers' actual costs. When the Legislature's mandate was fulfilled in 1993 by DSS's promulgation, DSS confirmed that the Legislature intended that the rate setting methodology consider the providers' actual costs for services:

> The Legislature's general objective in enacting Chapter 53 of the Laws of 1990 was to require the Department to develop a rate setting methodology for personal care services that considers personal care service providers' *actual costs* of providing services to [Medicaid] recipients. Specifically, the Legislature directed the Department to develop a rate setting methodology that considers *certain minimal factors*. (R-97) (emphasis added).

The Legislature's intent is the controlling factor in this case. Under New York law, the central tenet of statutory construction is that a statute should be construed to effectuate the intent of the Legislature. *People v. Finnegan*, 85 N.Y.2d 53, 58 (1994), *cert. denied*, 516 U.S. 919 (1995). Further,

> [i]n the interpretation of statutes, the purpose of the act and the objectives to be accomplished must be considered. It is the legislative intent that is the great and controlling principle, and the primary consideration of the courts in the construction of statutory provisions is to ascertain and give effect to that intent.

People v. Cypress Hills Cemetery, 208 A.D.2d 247, 252 (2d Dept. 1995), *citing*, McKinney's Consolidated Laws of N.Y., Book 1, Statutes § 92(a); *Niesig v. Team I*, 76 N.Y.2d 363 (1990).[7]

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7. Significantly, the Court of Appeals never reached this issue. Instead, the Court allowed the Attorney General to apply his interpretation on an *ad hoc* basis, with the criminal jury serving as the final arbiter.

The Attorney General has violated this basic tenet by demanding, in effect, that providers' reimbursement rates equal the rates charged to self-pay clients. Critically, the Attorney General's interpretation of "charges the general public" would render a providers' *actual costs* of providing services irrelevant and, instead, reimburse the provider at a rate that reflects the self-pay client's ability to pay, *not* the provider's actual costs. Moreover, the Attorney General's *ad hoc* definition of the appropriate reimbursement rate lacks a cognizable methodology and ignores the Legislature's plain directive that *at a minimum* the five factors listed above must be considered.[8]

In sum, the Legislature's intent was crystal clear when it gave DSS the mandate to develop a rate reimbursement methodology for personal case services: the methodology was to reflect providers' actual costs. The Attorney General's unauthorized and unsubstantiated interpretation of the "rate the provider charges the general public" at least ignores, and at worst, deliberately contravenes, the Legislature's intent.

B. The Attorney General's Interpretation Violates The Intent of the Regulating Agency.

The Attorney General's interpretation of the "general public" language of the Regulation violates the express intent of DSS, the agency charged with the development, implementation and interpretation of the Regulation at issue. The intent of the administrative agency that promulgated a regulation is key to the interpretation of a regulation. *Cortland-Clinton, Inc. v. New York State Dep't of Health*, 59 A.D.2d 228, 231 (4th Dept. 1977).

Effectuating the intent of the Legislature, DSS clearly stated that the intent behind the Regulation was to ensure that "personal care services payment rates would more closely reflect providers' *actual costs* of providing personal care services" to Medicaid recipients. For example, the intent to base the reimbursement

8. UHC's brief fully discusses the undisputed failure (or refusal) of DSS or the Legislature to explicate or define the "public charge" language the Attorney General relies upon.

methodology on providers' actual costs is found, *inter alia*, in the alternative rate setting methodologies considered by DSS, but ultimately rejected. DSS considered a methodology based on a uniform price or fee set by DSS that it would pay to all providers regardless of the providers' actual costs. DSS also considered a methodology by which "providers' existing negotiated rates would simply be adjusted by a trend factor to account for inflationary increases in their costs of doing business."[9]

Finally, DSS's Regulatory Flexibility Analysis summarizes its conclusion regarding the effect of the Regulation:

> The rate methodology that the proposed regulations would require may affect the rates at which providers are paid for personal care services. *Such payment rates should, however, be equitable because they would reflect providers' actual and allowable costs of doing business* and include an adjustment to account for inflationary increases in such costs. (R-108) (emphasis added).

Given the legislative mandate, as well as DSS's intent in promulgating the Regulation, there can be no doubt that DSS's rate reimbursement methodology was meant to reflect the providers' actual costs for services rendered to Medicaid recipients.

As a final matter, the rules of administrative construction preclude the Attorney General's interpretation of the "public charge" regulation and compel this Court's rejection of that construction. Where the plain meaning of a regulatory term cannot be construed from the face of the regulation, the administrative intent behind the promulgation of the regulation should be looked to. *Cortland-Clinton, Inc. v. New York State Dep't of Health*, *supra*, at 231; *see also New York State Clinical*

9. Both alternatives were rejected: the former because DSS did not have enough data on providers' actual costs of doing business, the latter because the methodology would not reflect providers's actual costs of doing business.

Laboratory Association, Inc. v. Kaladjian, 194 A.D.2d 189, 193 (3d Dept. 1993), *aff'd*, 85 N.Y.2d 346 (1995) (refusing to uphold DSS's interpretation of its own regulation where such an interpretation "significantly alters the language of the regulation and is in disharmony with its administrative history"); *and see People v. Cypress Hills Cemetery*, *supra*, at 251.

In sum, it is clear that the phrase "charges to the general public" cannot mean the highly variable rates that providers charge self-pay clients whose personal circumstances and service needs differ widely and unpredictably. The Attorney General would have this Court believe otherwise, but his interpretation flies in the face of the legislative intent underlying the Regulation because it fails to consider providers' *actual costs*. It also clearly contravenes DSS's own words which speak for themselves: the regulation was enacted to ensure that "personal care services payment rates would more closely reflect providers' *actual costs* of providing personal care services" to Medicaid recipients. The Attorney General cannot and should not be allowed to define a regulatory term in a way that is clearly contrary to the express purpose and intent of the Regulation — and do so in a manner that would have Draconian civil, administrative and criminal consequences to unwitting providers.

C. The Attorney General's Redefinition of the Medicaid Reimbursement Rate Violates New York State Public Policy and Will Have a Devastating Effect on the Personal Services Program in New York.

As noted above, the Legislature has plainly declared its commitment to expanding the role of home health care agencies which provide personal care. When the Legislature enacted statutory authority for certified and licensed home health agencies, it revealed its deep-rooted commitment to *expanding* home care services to New York "as a viable part of the health care system and as an alternative to institutional care. . . ." *See* Public Health Law § 3600. (*See*, *supra*, p. 6.)

The Attorney General's efforts to impose a new Medicaid reimbursement rate, with concomitant civil and criminal

penalties, contravene a fundamental state public policy favoring the expanding role of home health services. If the Attorney General unilaterally redefines the reimbursement rate as a rate less than that reflected in the contract entered into by the counties and providers — and thereby less than providers' actual cost of providing services — and recoups the putative "overreimbursement" that personal care providers have received since 1994 to date, personal care providers will go out of business. If these providers are required to pay hundreds of thousands or millions of dollars, as the Attorney General now seeks from UHC, providers will have literally no choice but to go into bankruptcy. Moreover, the owners and operators will also be subject to criminal sanctions under the Attorney General's theory — even though the monies they accepted were based on actual cost rates determined by the State, in accordance with the State-created methodology and in accordance with the express terms of their contracts. If personal care providers go out of business, New York State's elderly, disabled and infirm will be deprived of access to the personal care services they need and currently receive. This is an untenable and inhumane result, and is diametrically opposed to the unequivocal public policy articulated by the Legislature in its pronouncement of intent to provide health care services for the needy.

Even if the Attorney General's reimbursement scenario is implemented prospectively only, it still will have a catastrophic impact on the ability of the uninsured elderly, disabled, ill and infirm to receive essential personal care services. As noted above, by definition, the reimbursement rates established in accordance with 18 N.Y.C.R.R. § 505.14(h)(7) reflect the *actual costs* to the providers. Thus, to the extent that personal care providers will be required to accept less than the established Medicaid rate, there will be a huge shortfall between the actual cost of services rendered to Medicaid recipients versus the reimbursement the agencies receive. If a Medicaid

reimbursement rate is tied to the lowest self-pay rate the provider receives, providers will be faced with a perverse set of options: (1) stop providing services to self-pay clients altogether; (2) raise the rates of self-pay clients to the established Medicaid rate, thereby shifting to the uninsured sector of our population an even greater financial burden; or (3) stop providing personal services to Medicaid recipients.[10] Any of these options will lead to a reduction in home care service to some segment of the population — a result which is patently contrary to state public policy and is clearly undesirable, in terms of the safety, health and well-being of the individual, and of all medically needy New Yorkers.[11]

The Attorney General's unprecedented enforcement campaign will also lead inexorably to the increased institutionalization of the elderly and the infirm, which is directly contrary to the policy articulated by the New York State Legislature when it enacted Article 36 of the N.Y. Public Health Law. Individuals who are no longer able to find or afford personal care services may have no alternative other than to resort to State-funded institutionalization. They will, in short, obtain hospital or nursing home care at far higher costs to the taxpayer than if those services were provided at home, and they will be cared for in a highly (and unnecessarily) restrictive environment. This, of course, would be antithetical to New York State's public health objectives and public policy.

The Attorney General's prosecutorial scheme creates other significant complications in addition to those noted above.

10. The uninsured, who often cannot pay full fare, obviously should not be charged list price and a provider's charitable or benevolent motivation should not be what criminalizes its actions.

11. As a practical matter, the vast majority of self-pay clients will be left with no access to personal care services, particularly if they live in small or rural areas. By definition, such areas do not have a wide array of alternative services or charitable providers available in the community. Thus, those needy individuals who have no alterative providers available will be left in a terrible situation in which personal care needs will simply go unmet.

The State has at times produced its final Medicaid rates ten months after the rate year has commenced. Therefore, where the rates set in contracts with private paying clients turn out, ultimately, to be lower than the Medicaid rates, personal care providers have a dilemma. To avoid the Attorney General's civil and criminal sanctions,[12] the providers could, theoretically, try to recoup from the self-pay clients a higher rate retroactively. As a practical matter, however, the providers' chances of success using this method are virtually nil. Parties contract in advance for services to be rendered in exchange for a certain payment. Providers and those with whom they contract cannot be expected to alter the material terms of their contracts almost a year into those contracts — if, indeed, the contracts have not by then already been fully performed.

As a final matter, the Attorney General's actions to date have already put personal care providers in the State of New York in a state of crisis. They have complied with the rules and regulations set forth by DSS, they have provided their annual cost reports, and they have been paid their actual costs pursuant to the Medicaid reimbursement rate set by the State. As a result of the Attorney General's personal care initiative, no provider now knows for certain what standard will be applied to its business, whether that standard will be applied retroactively or prospectively, or whether it will arise in a civil and/or a criminal context. In short, the Attorney General's interpretation of the "general public" charge has already created, and will continue to create, a highly volatile situation.[13] The destablizing effect of

12. To compound the problem, once a criminal prosecution is initiated by indictment, the provider must cease all operations.

13. In addition, the Attorney General's efforts to engraft upon the regulation his own rate-making mechanism raises the specter of unpredictable and inconsistent variations in the interpretation of the regulation in the future. The very "flexibility" of a regulation that would, according to *this* Attorney General, allow him to prosecute some categories of personal care providers and not others, and would allow the *next* Attorney General, or the Attorney General who follows him, to

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the Attorney General's reimbursement strategy puts New York State's entire personal care network in serious jeopardy and violates fundamental principles of fairness and due process, and contravenes New York public policy favoring the expansion of personal care services.

II.

CRIMINAL PROSECUTION OF A HOME CARE SERVICES PROVIDER ON THE BASIS OF AN ALLEGED VIOLATION OF A MEDICAID REIMBURSEMENT REGULATION, PROMULGATED BY A STATE ADMINISTRATIVE AGENCY, IS UNAUTHORIZED, IMPERMISSIBLE AND UNDERMINES THE PURPOSE AND INTENT OF THE STATUTE, REGULATIONS AND NEW YORK STATE PUBLIC POLICY

Trade organizations such as HCP are routinely engaged with the Legislature and regulatory agencies in the development of policies affecting the provision of health care services. However, where such policy is being shaped through criminal enforcement, or the chilling effect of the threat of such enforcement, the normal dynamics of policy development are entirely distorted. For decades, health care policy has been shaped by the interactions of interest groups with regulators and legislators. Criminal enforcement did not present issues of usurpation of power: such enforcement was based on a clear statute and well-defined usage. This process has now been reversed under the rubric of fighting potential health care fraud. It is now routine to find agencies such as New York's Medicaid Fraud Control Unit (MFCU) enforcing their own unique concept of health care policy.

(Cont'd)
interpret that same regulation differently. The consequences are obvious and frightening: providers who acted in 1998 in a manner that was proper and consistent with *this* Attorney General's approach to the regulation may find themselves prosecuted tomorrow, or next year, because another Attorney General takes a different (and unpredictable) view of this regulation.

It is critical for this Court to grant certiorari in this case to assure that the balance of prosecutorial power does not tip impermissibly into the realm of policy-making. If the generic reference to compliance "with all applicable laws and regulations" imbues prosecutors with the power to prosecute, they will in effect be given virtually unfettered ability to implement a state-wide campaign to enforce their interpretations of particular regulations.[14]

A prosecuting agency's ability to threaten and assert such broad power should be subject to a pre-emptive legal challenge, such as declaratory judgment actions of the sort commenced by UHC. Only in this manner can Courts ensure that the liberty and advocacy rights of similarly affected providers are not violated by the threat of facing the Grand Jury if they cannot afford to settle with the MFCU. In the absence of this Court's protection, providers are faced with the development of policy through the criminalization of a failure, intentional or inadvertent, to comply with all "applicable regulations" — an undefined phrase until such time as the prosecutor decides to interpret and, simultaneously, enforce it.

The particular regulation used by the MFCU herein involves an area of health care which not only affects payments to Medicaid but greatly influences how care will be priced to those who are not Medicaid recipients. It does so by incorporating the broad terms "charges to the general public." The Court of Appeals failed to provide a limiting construction of these terms in the decision below. Instead, the Court simply noted that these terms exist in similar, although not identical language, in other aspects of the Medicaid, Medicare and even the Veteran's Administration laws and regulations. The Court failed to appreciate how such regulations must be defined before they

14. In fact, this is what occurred herein. The MFCU instituted a state-wide review of the home care industry's compliance with the public charge regulations. While many agencies were able to settle with the MFCU and pay back sums claimed by the AG to be "overpayments" under the regulation, those who could not settle were subject to prosecution.

can ever be effectively implemented in the realities of the health care industry. In fact, the Federal government has rarely implemented regulations such as the "public charge" concept without exhaustively defining such concepts *in terms of how they would be applied.*

For example, Federal regulations authorize the use of a "usual and customary" charge limitation only in very narrow areas as defined by the type of service being provided. The Attorney General cited generally to such provisions before the state high court without any elaboration as to the guidelines, criteria and standards which are exclusively related thereto. Terms such as the "usual and customary charge" and the "general public" may only gain meaning as structured and defined by a payor for specific provider types (*e.g.*, pharmacy, physicians, hospitals). With respect to Medicaid standards, the only areas wherein a "usual" and/or "customary" charge is required are pharmacy and in-patient hospital services. *See* 42 C.F.R. § 447.331(b)(2) (drugs: "usual and customary charge"); 42 C.F.R. § 447.271 (inpatient services: "customary charge"); 42 C.F.R. § 447.325 (Other in-patient and Outpatient Services: "prevailing charges in the locality for comparable services under comparable circumstances"). For personal care, no specific payment limitation exists aside from 42 U.S.C. § 1396-a(a)(30).

The Attorney General's citation to other regulatory provisions before the Court of Appeals differed significantly with the position taken at the intermediate and trial court levels. The Attorney General cited to such laws without stating whether any standards were developed or disseminated to the particular industry involved with respect to each category of service. In fact, such concepts have been dormant without the necessary development of standards and definitions by the affected agency. An example of how other payors administer these terms is reflected in Medicare program standards. For some time, the Department of Health and Human Services (HHS) has sought to finalize a *proposed* regulation which would define "actual charge". Through appropriate rule making, the agency has stated

a desire to define the term. *See* 62 Fed. Reg. 33158, 33185 (Proposed Fee Code Changes for 1998) (reproduced in relevant part in Appendix B).

In other areas of federal regulation, the federal government sought to define "usual charges" as that term is used in 42 C.F.R. § 1001.701(a)(1). HHS began to consider defining the key terms in this regulation in April 1990. *See* 55 Fed. Reg. 12205-02 (Apr. 2, 1990). In January 1992, HHS determined *not* to define the term even though it "would be helpful to the public to have some additional guidance on what standards the OIG intends to apply" in such cases. *See* 57 Fed. Reg. 3298-01 (Jan. 29, 1992). By September of 1997, HHS once again solicited comments on the scope of this general rule. *See* 62 Fed. Reg. 47182-01 (Sep. 8, 1997) (reproduced in relevant part in Appendix C). After almost a decade of deliberating over how such terms should be defined, the Federal government decided that the use of such regulation was outmoded given modern day payment systems and that the lack of clarity would impede enforcement in any event, and declined to define the term. *See* 63 Fed. Reg. 46676 (Sep. 2, 1998) (reproduced in relevant part in Appendix D). Most recently, in May of this year, HHS has once again placed the definition of such terms on its schedule of regulatory agenda items as set forth in May 2001. *See* 66 Fed. Reg. 25399 (May 14, 2001). This roller-coaster of regulatory activity/ inactivity in defining key terms of an enforcement regulation reflects the extreme vagueness of the underlying concept of limiting Medicaid payments to amounts "usually charged" or charged to the "general public".

It is also significant that the Attorney General avoided all references to a State regulation which prohibits providers from submitting claims to the Medicaid program which are "substantially in excess" of the provider's "usual charges or costs" to the "general public." *See generally* 18 N.Y.C.R.R. § 515.2. That regulation, which relates to all Medicaid programs, affirmatively describes certain conduct to be an unacceptable

practice. 18 N.Y.C.R.R. § 515.2.[15] Included are the submission of claims in "amounts substantially in excess of the customary charges or costs to the general public." *Id.* The contrast in wording between the public charge regulation and the unacceptable practice regulation shows that the public charge regulation, on its face, does not speak to, or direct compliance from, the general public.

As noted by the Federal government when it failed to define "usual charge", this concept is outdated and lacks support in today's age. For example, in the State of Connecticut, the Federal government previously invalidated the use of a public charge limitation in the Medicaid context when it meant reimbursing providers at below Medicaid costs. *See* Dec. of Admin. of Dep't of Health, Educ. and Welfare, dated May 28, 1971 (reproduced in relevant part in Appendix E). This decision reflects the basic posture of most agencies which have carefully reviewed whether the economics of using non-Medicaid payors such as private individuals would properly reflect actual Medicaid costs and how the use of a "public charge" may have adverse and inflationary effects on prices paid by the "public" at large. This is an important matter of public policy which should not be left to criminal enforcement agencies for definition and promulgation of standards.

Unlimited criminalization of the Medicaid regulations in this fashion provides inadequate notice and invites — indeed, begs — the other vice that the void-for-vagueness doctrine is concerned with: arbitrary prosecution. The prosecutors in this case are saying nothing less than that, in the case of an individual

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15. Section 515.2 reads, in pertinent part:

> (b) *Conduct included.* An *unacceptable practice* is conduct which constitutes fraud or abuse and includes the practices specifically enumerated in this subdivision. (1) False claims. (i) Submitting, or causing to be submitted, a claim or claims for: . . . *(d)* amounts substantially in excess of the customary charges or costs to the general public.

18 N.Y.C.R.R. § 515.2(b).

who signs a Medicaid reimbursement claim certification, they can prosecute that individual for any violation of any federal or state regulation they believe the individual violated. By this sleight of hand, a panoply of administrative regulations, never enacted as criminal laws by any legislature, become, in effect, criminal statutes.[16] This is clearly a dangerous and untenable outcome.

III.

THE ATTORNEY GENERAL ENTERED INTO THE VACUUM CREATED BY THE STATE REGULATORS WHERE THEY NEITHER DEFINED NOR IMPLEMENTED THE PUBLIC CHARGE CONCEPT

As is evidenced by the State's own internal memoranda, basic policy issues were involved in deciding whether to include individuals who are insured through HMOs or managed care entities as part of the defined "public" to be included in the "public charge concept" because such inclusion would have an inflationary effect and, thus, run to the detriment of the State as a whole:

> I note that our decision on this matter may have far-reaching implications for the provider community. Specifically, I understand that providers such as laboratories, pharmacies, DME dealers, etc., may have contractual agreements with hospital facilities/ medical institutions or other third party payors to provide goods and services at a rate lower than that which is reimbursed by Medicaid. Any decision to include such entities under the general definition of the "general public" may result in the need for providers to re-evaluate their contractual agreements with such entities. (R-111-112)

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16. Critically, the case was all but presented as such at the trial below. The prosecutor presented the case as involving the violation of a "simple rule" that a private person cannot be charged less than Medicaid.

The State agency which had promulgated this regulation was itself perplexed in trying to construe the term internally and, when confronted with whether a particular segment of the "general public" should be included or not, always opted for exclusion so as not raise any inflationary concerns.[17]

The Attorney General's own interpretation of "public" within this case is narrowed to those who pay out of their own pocket. Such a restrictive interpretation is at odds with both common usage and the dictionary definition of the term "general public." He has not included Medicaid beneficiaries within the term "general public," nor has he included any other clients of UHC who have payments made under managed care programs, county-run programs for the elderly, or special programs associated with child protective services.

In addition to these deficiencies, the Attorney General has failed to demonstrate how his position on the interpretation of the regulation would, in any way, further his stated purpose of reducing health care fraud in New York or otherwise serve the public interest.

CONCLUSION

For the foregoing reasons, HCP respectfully requests that this Court issue a writ of Certiorari to the New York Court of Appeals to review the constitutional issues presented herein and award such other relief as this Court shall deem just, proper or equitable.

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17. Indeed, the Attorney General's enforcement of the regulation in this and other cases will cause private citizens across the State to incur higher prices for the delivery of home care services to the extent that they have no insurance or are not enrolled in any managed care plans. This is due to his position that only self-pay individuals are members of the "general public." As such, the Attorney General's interpretation prohibits the giving of any discounts to such self-paying patients while allowing discounts to any other payor source. The economic effects of this position evidence its perversion because they encourage cost shifting from large organizations to those who are least capable of paying for their care.

Respectfully submitted,

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